STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315054	A. Building B. Wing	10/12/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Our Ladys Center for Rehabilitation & Healthcare	1100 Clematis Ave Pleasantville, NJ 08232

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. 10648 Based on observation, interview and record review, it was determined that the facility failed to maintain the self esteem and self worth of all residents. This deficient practice affected 1 of 27 core sampled residents reviewed(Residents #178) and was evidenced by the following: On 10/03/18 at 09:50 AM, Resident #178's physician came to the nurses station where there were three nurses sitting and in a loud voice stated that her resident, Resident # 178, told her that the resident had put the call light on the previous night at 11:00 PM and no one came until 01:00 AM this morning. On 10/04/18 at 12:45 PM, the surveyor observed Resident # 178 seated in a wheelchair and was awake and alert. When interviewed at this time, the resident stated that two nights ago, he/she had put the call light on at 11:00 PM and that someone came in to the room. This staff member told the resident that the staff were changing shifts. The resident stated that this staff member did not return so the resident kept pushing the call button. Resident # 178 stated that it was not until 01:00 AM that someone finally answered the call light. The resident stated that he/she knew the times because of the clock on the wall. The resident pointed up to the clock on the wall that was over the TV. Resident # 178 stated that she felt ignored by the staff and that this made the resident feel angry. On 10/09/18 at 10:18 AM, the surveyor observed that Resident # 178 was awake and alert in bed. The head of the resident's bed was lower that the foot of the bed. There was a box of colostomy supplies on the bed. The resident was partially covered by a blanket. When interviewed at this time, the resident stated that there were staff in the room to do a treatment a little while ago and had left the resident's head of the bed down and not fully covered. The resident stated that he/she could not find the call light to have someone come in to assist the resident with morning care. The surveyor observed that the call light was wedged between the headboard and the wall, out of the resident's reach and sight. The resident stated that the service here at the facility was terrible and that it's a b**ch trying to get someone to come in to help you. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	When interviewed by the surveyor on 10/12/18 at 9:55 a.m., both the Director of Nurses (DON) and the Assistant DON stated that after they were made aware of Resident #178's complaints, neither of them spoke to the resident. When interviewed by the surveyor on 10/12/18 at 10:05 a.m., the Unit Manager where Resident #178 resided stated that she spoke with the resident right after the incident happened but did not document the conversation. The Unit Manager added that she did not ask the resident why he/she put the call light on and did not interview the 11:00 p.m. to 7:00 a.m. CNA that had been assigned to the resident the night of the incident. A plan of care for Activity of Daily Living (ADLs) was developed by the facility staff for Resident #178, on 10/3/18. The interventions included the assistance of one staff member to assist the resident with ADLs. In addition, the resident also had a plan of care for being at risk for falls. The interventions included keeping the call light in reach while in the room. NJAC 8:39-4.1(a)(12)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. 10648 Based on observation, interview and record review, it was determined that the facility failed to provide appropriate care and services to 1 of 3 residents (Resident #52) who were receiving treatment for a Urinary Tract Infection (UTI) and was evidenced by the following: Reference: New Jersey Statutes, Annotated Title 45, Chapter 11. Nursing Board The Nurse Practice Act for the State of New Jersey states; The practice of nursing as a registered professional nurse is defined as diagnosing and treating human responses to actual or potential physical and emotional health problems, through such services as case finding, health teaching, health counseling, and provision of care supportive to or restorative of life and well being, and executing medical regimens as prescribed by a licensed or otherwise legally authorized physician or dentist. On 10/02/18 at 01:35 PM and on 10/03/18 at 12:09 PM, the surveyor observed that Resident # 52 was seated in a wheelchair in her room. The resident said hello to the surveyor but did not converse with the surveyor. According to the medical record, Resident #52, who had diagnoses that included elevated White Blood Cell Count, was evaluated by the Advanced Practice Nurse (APN) on 09/23/18 and lab work was ordered. On 09/27/18, this APN ordered Resident #52 to have a urinalysis and a urine Culture and Sensitivity (C & S) obtained. The order also indicated that the urine C & S could be obtained via straight catheterization. This procedure involves inserting a catheter into the urethra and into the bladder to obtain a urine specimen. The resident's urine C & S was obtained. The lab had been notified to pick up the specimen. On 10/1/18, the organism was identified as providencia stuarti by the lab. Documentation in the medication record dated 10/2/18 indicated that the resident was started on Cipro antibiotic for UTI, no adverse effects noted, thus far, no complaints of pain or burning upon urination, fluids offered and accepted. A further review of the medical record revealed that there was no documentation from the APN related to his rationale prior ordering the urine C & S through a straight catheterization procedure. In addition, there was no documentation from the facility staff regarding the signs and symptoms that the resident exhibited indicative of a UTI. According to the Significant Change Resident Assessment Instruments (RAI) dated 8/8/18 and 5/15/18, Resident #52 had a Brief Interview for Mental Status (BIMS) score of 11 out of 15 indicating that the resident was not cognitively impaired. In addition, this RAI indicated that Resident #52 had adequate hearing, clear speech, was able to understand and to be understood. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	When interviewed by the surveyor on 10/12/18 at 8:30 AM, the APN stated that he ordered that a urine C & S on Resident #52 to rule out a UTI. The APN stated that he ordered the specimen to be obtained by straight catheterization because he wanted to make sure that he had a good sample with no contamination. The APN stated that the resident had cognitive and communication deficits so he had not spoken to Resident #52 regarding any symptoms of a UTI or for getting the resident's permission to perform an invasive catheterization to obtain the urine specimen. When ask about the organism that was identified in the urine specimen, the APN stated he did not know what the organism was or how the resident could have gotten it. The APN also stated that he was not sure if it was him or the resident's attending physician that ordered the antibiotic for this resident. When interviewed by the surveyor on 10/10/18 at 10:49 AM, the unit nurse stated that the lab work results were in the resident's record. The nurse stated that the urine C & S was obtained through a straight catheterization and that the APN ordered the invasive procedure because the resident's White Blood Cells (BC) were elevated. This nurse also stated that she was the one who performed the Urine C & S on Resident #52 and felt bad about it. NJAC 8:39-27.1(a)

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F 0661 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure necessary information is communicated to the resident, and receiving health care provider at the time of a planned discharge. 39242 Based on interview and record review, it was determined that the attending physician failed to document a summary of a resident's stay and course of treatment while at the facility. This deficient practice occurred in 1 of 3 (Resident #129) residents whose closed records were reviewed and was evidenced by the following: A review of the closed medical record for Resident #129 revealed that there was no physician discharge summary documented. When interviewed by the surveyor on 10/11/18 at 03:28 PM, the Corporate Nurse, who had reviewed the medical record, stated I don't see it. It should be in here. On the same day at 03:49 PM, the Corporate Nurse told the surveyor that they did not have the discharge summary from the physician for Resident #129. When interviewed by the surveyor on 10/12/18 at 12:02 PM, the Corporate Administrator said that the facility uses a checklist to ensure that the medical record contains all required documentation when a resident gets discharged however, the staff member that was responsible for this form was not working that day. NJAC 8:39-35.2(d)(16)

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F 0728 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that nurse aides who have worked more than 4 months, are trained and competent; and nurse aides who have worked less than 4 months are enrolled in appropriate training. 10648 Based on interview and record review, it was determined that the facility failed to ensure that all full time nursing assistants who have not completed an approved training course were enrolled within the mandated time frame. This deficient practice occurred to 1 of 2 nursing assistants whose personnel files were reviewed and was evidenced by the following: According to the personnel file, Nursing Assistant (NA #1) was hired on 8/5/18 by the facility as a full time Certified Nursing Assistant (CNA) on 8/5/18 on the 11:00 p.m. to 7:00 a.m. shift. The Employment Application that was completed by NA #1 indicated that NA #1 had been previously employed by this facility from 5/8/18 to 6/20/18 as a CNA whose duties included providing care to residents performing ADLs that they can't do for themselves. NA #1 documented that the reason she left her employment with this facility on 6/20/18 was that she was taken off of the schedule due to not having a certification. NA #1 had documented on this application that she was a CNA under the section for Professional, Certified and Managerial Applicants. According to the facility's Personnel/Payroll Action Form, NA #1 was rehired on 8/2/18 for a full time position as a CNA. This form had been signed by a Human Resource (HR) staff member who was no longer employed by the facility. According to another Personnel/Payroll Action Form, NA #1 was terminated on 10/1/18. This form had been signed by the current HR staff member. When interviewed by the surveyor on 10/10/18 at 11:00 a.m., the current HR staff member stated that NA #1 was terminated on 10/1/18 because NA #1 was not certified within the required 120 days. The HR staff member stated that she referred this issue to the Corporate Administrator (LNHA). According to the Daily Staffing Sheets that were provided by the facility, NA #1 was on the schedule to work 16 shifts in August of 2018, starting on 8/8/18 and 13 shifts in Setember of 2018. The facility could not produce a daily schedule for Setember 1, 2018 through September 4, 2018. According to the facility's Hiring Policy and Procedure, prior to hiring, the Nurses Aide's certification will be checked through the NJ Nurse Aide Registry. The documentation from the registry will be maintained in the employee's personnel file. When interviewed by the surveyor on 10/12/18 at 10:10 a.m., the Corporate LNHA stated that NA #1 had told the facility that she was enrolled in a CNA program however, the facility never verified this prior to hiring her. NJAC 8:39-43.1

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F 0729 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Verify that a nurse aide has been trained; and if they haven't worked as a nurse aide for 2 years, receive retraining. 10648 Based on interview and record review, it was determined that the facility failed to ensure that all certified nursing staff hired by the facility had certifications in good standing. This deficient practice occurred to 1 of 2 employees hired within the last four months and were listed as Certified Nursing Assistants (CNA). The evidence is as follows: According to the facility's Personnel/Payroll Action Form, Nursing Assistant (NA #1) was rehired on 8/2/18 for a full time position as a CNA. When reviewed, the personnel file for NA #1 did not have proof that the registry for nurses aides certification was checked to ensure that her certification was in good standing. When interviewed by the surveyor on 10/10/18 at 11:00 a.m., the current Human Resource (HR) staff member stated that NA #1 was terminated on 10/1/18 because NA #1 was not certified within the required 120 days. The HR staff member stated that she referred this issue to the Corporate Administrator (LNHA). According to the facility's Hiring Policy and Procedure, prior to hiring, the Nurses Aide's certification will be checked through the New Jersey (NJ) Nurse Aide Registry. The documentation from the registry will be maintained in the employee's personnel file. When interviewed by the surveyor on 10/12/18 at 10:10 a.m., the Corporate LNHA stated that the facility had not checked the registry to ensure that NA #1 had a certification in good standing prior to hiring her. NJAC 8:39-43.15(a)

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F 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Post nurse staffing information every day. 10648 Based on interview and record review, it was determined that the facility failed to post staffing information each shift and ensure that the staffing information was complete. This deficient practice was evidenced by the following: On 10/12/18 at 9:40 a.m., the surveyor observed that the staffing information was located on the counter of the receptionist's desk by the entrance of the facility. The surveyor also observed that there were staffing sheets from previous days behind the staffing information for 10/12/18. The surveyor also observed that the staffing form that was posted by the facility did not contain the actual hours that the Registered Nurses (RN), Licensed Practical Nurses (LPN) and Certified Nursing Assistants (CNA) worked and the ratio of staff to residents. A review of the information revealed the following: 1) On 10/11/18, the staffing information for the evening shift was blank on the staffing form. 2) On 10/10/18, there was no staff sheet available. 3) On 10/09/18, the staffing information for the night shift was blank on the staffing form. 4) On 10/07/18 and on 10/06/18, the staffing information for the days and evening shifts were blank on the staffing form. 5) On 10/05/18, the staffing information for the day shift was blank on the staffing form. 6) There were no staffing sheets available for 09/26/18 through 10/03/18 and for 09/23/18 and 09/24/18. 7) On 09/25/18, the staffing information for the evening shift was blank on the staffing form. 8) On 09/22/18, the staffing information for the evening and night shifts were blank on the staffing sheets. When interviewed by the surveyor on 10/12/18 at 11:26 a.m., the staffing coordinator stated that she had staffing forms that contained all of the required staffing information required however, the facility's policy was to post the form that the surveyor located on the counter of the receptionist's desk. NJAC 8:39-41.2

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 10648 Based on observation, interview and record review, it was determined that the facility failed to ensure that all nurses administer all prescribed medications to all residents. This deficient practice occurred to 1 of 7 residents (Resident #179) observed during the medication pass and was evidenced by the following: According to the medical record, Resident #179 had diagnosis that included Adjustment disorder with mixed anxiety and depressed mood; Dementia with behavior disturbance; Major depressive disorder, recurrent; anxiety disorder, unspecified. According to the Admission Resident Assessment Instrument (RAI) dated 10/05/18, Resident #179 was alert and oriented but had been feeling down for the previous seven to eleven days and had trouble with sleep for the previous two to six days. On 10/05/18 at 8:52 a.m., the surveyor observed Resident #179 receive four medications during the medication pass. These medications included Miralax 17.5 grams in four ounces of water, Vibratab 100 milligrams (mg), Eldepryl 5 mg and Venlafaxine XR 75 mg. Prior to taking the medications, Resident #179 requested to see the containers that held his/her medications. The Registered Nurse (RN #1) brought the BINGO cards that contained the pill forms of the medications into the resident's room for the resident to review. After reading the BINGO cards and looking at the medications that he/she received from RN #1, Resident #179 took the medication without difficulty or questions. On 10/05/18 at 12:30 p.m., during the reconciliation of physicians' orders in the medical record, it was revealed that Resident #179 was ordered to receive Venlafaxine XR 75 mg with Venlafaxine 37.5 mg by mouth (PO) daily. Venlafaxine is used to treat depression, and anxiety. During the medication pass on 10/05/18 at 08:42 a.m., the surveyor observed that the RN #1 poured and administered Venlafaxine 75 mg but not the 37.5 mg dose of Venlafaxine. A review of Resident #179's October 2018 Medication Administration Record (MAR) revealed the order for the Venlafaxine 37.5 mg dose however, there was no time of administration written and the Venlafaxine 37.5 mg had not been signed as administered to the resident on 10/01/18, 10/02/18, 10/03/18, 10/04/18 as well as 10/05/18, the day of the medication pass observation. This was verified with RN #1 on 10/05/18 at 12:40 PM who stated, I didn't see a time written on the MAR so I thought that it was a PRN. On 10/05/18 at 1:39 p.m.,he MAR was reviewed by the Director of Nurses (DON) who acknowledged the omissions of the resident's Venlafaxine 37.5 mg by multiple nurses on multiple days. The DON stated that the nurses missed giving the resident the 37.5 dose of Venlafaxine for five days. The DON added that the nurses do a 24 hour chart check daily and that this error should have been caught by the nurse reviewing the medical record and the MAR. She stated that the physician had been notified and directed them to give resident #179 a dose of Venlafaxine 37.5 mg now. The DON also stated that an investigation will be conducted and the documentation will be provided to the surveyor. According to the medical record, the Venlafaxine XR 75 mg and the Venlafaxine 37.5 mg were ordered on 9/28/18. According to the MAR, the Venlafaxine 37.5 mg was administered once on 9/30/18. It was not administered on 9/29/18. The BINGO card, which contained the tablets of Venlafaxine 37.5 mg was observed to have only one tablet missing leaving 13 tablets in the card. NJAC 8:39-29.3(a)(5 & 6)

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. 10648 Based on interview and record review, it was determined that the facility failed to identify issues then develop and implement a plan to address preventable events that adversely affect residents in a Quality Assessment and Assurance (QAA) program. This deficient practice was evidenced by the following: When interviewed on 10/12/18 at 10:25 a.m., the facility's Director of Nurses (DON) stated the following: 1) There was no QAA program for the Antibiotic Stewardship or the for the use of antibiotic use for residents with Urinary Tract Infections (UTI). Refer to F880 and F881 2) There was no QAA program for the hiring of Certified Nursing Assistance (CNA), including a check of the New Jersey (NJ) Nurse Aide Registry prior to hire. Refer to F729 NJAC 8:39-33.1 and 33.2

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F 0868 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Have the Quality Assessment and Assurance group have the required members and meet at least quarterly 10648 Based on interview and record review, it was determined that the facility failed to ensure that the Quality Assessment and Assurance (QAA) committee conducted meetings on a quarterly basis for two of four quarters, based on the facility's schedule. In addition, the facility failed to ensure that the required members were present during all QAA meetings. This occurred on 2 of the 4 QAA meetings that were conducted. This deficient practice was evidenced by the following: According to the data provided by the facility, the following facility staff had not attended the quarterly QAA meetings, as required: 1) There was no physician, including the Medical Director or another designated physician, in attendance for the QAA meetings that were held on 07/25/17, 04/05/18 and 07/05/18. 2) An Administrator (LNHA)) was not in attendance for the QAA meetings that were held on 04/05/18 and 07/25/18. 3) There was no evidence provided by the facility indicating that a QAA meeting was conducted on a quarterly basis as required. QAA meeting sign in sheets were provided for 04/27/17, 07/25/17, 04/05/18 and 07/05/18 however, there were no sign in sheets for the quarterly meetings that should have been conducted in October of 2017 and January of 2018. When interviewed by the surveyor on 10/12/18 at 10:25 a.m., the Director of Nursing (DON) stated that, based on the QAA meeting sign in sheets for 04/27/17, 07/25/17, 04/05/18 and 07/05/18, a physician and/or LNHA were not in attendance at all meetings, as required. NJAC 8:39-33.1(b)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 10648 Based on observation and interview, it was determined that the facility failed to follow appropriate infection control procedures for the use of antibiotics in 1 of 1 resident reviewed for UTI (Resident #52) and for the implementation of an effective Infection Control program. This deficient practice was evidenced by the following: 1) On 10/02/18 at 01:35 p.m., the surveyor observed Resident # 52 seated in a wheelchair in her room. The resident was awake and alert but did not respond when spoken to by the surveyor. The surveyor also observed the resident seated in a wheelchair, in his/her room, on 10/03/18 at 12:09 p.m. According to the Significant Change Resident Assessment Instruments (RAI) dated 8/8/18 and 5/15/18, Resident #52, who was [AGE] years old, had a Brief Interview for Mental Status (BIMS) conducted that revealed a score of 11 out 15, indicating that the resident was not cognitively impaired. Both of these assessments also revealed that Resident #52 had adequate hearing, adequate vision with corrective lenses, clear speech and the ability to be understood and to understand. According to the list in the medical record, Resident #52 had diagnosis that included elevated White Blood Cell count. A review of the medical record revealed that on 09/23/18 at 15:56 (3:56 p.m.), Resident #52 was seen and evaluated by the Advanced Practice Nurse (APN). According to this note, the APN ordered lab work for the resident. According to a note dated 09/27/18 at 18:41 (6:41 p.m.), the APN ordered a urinalysis and a urine culture and sensitivity (c & s) test to be obtained from the resident via a straight catheter. (A straight catheter is a hollow rubber tube that is inserted into the urethral opening into the bladder. It is removed once the specimen has been obtained). A late entry note dated 09/28/18 at 14:40 (2:40 p.m.), revealed that the urine specimens were obtained and sent to the lab. A review of the results of the urine c & s revealed that Resident #52 had an organism called Providencia Stuartii in his/her urine. Additional lab work that had been obtained on 09/26/18 revealed that the resident's White Blood Cells (WBC) were elevated. A note dated 10/01/18 at 19:01 (7:01 p.m.) indicated that a facility Registered Nurse (RN) called the resident's physician and spoke with the APN, who had orders. According to the physician's order sheet, Resident #52 was ordered to receive 500 milligrams (mg) of Cipro, an antibiotic, twice a day (BID) for seven days on 10/01/18. On 10/02/18 at 18:15 (6:15 p.m.), Resident #52 was started on the antibiotic for a UTI and that there were no adverse effects noted. This note also indicated that Resident #52 had no complaints of pain or burning upon urination . There were no notes documenting that Resident #52 had pain or burning upon urination by the nursing staff, the resident's physician or the APN prior to the orders for the urine tests via straight catheterization or the antibiotic. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315054	A. Building B. Wing	10/12/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Our Ladys Center for Rehabilitation & Healthcare	1100 Clematis Ave Pleasantville, NJ 08232

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	When interviewed by the surveyor on 10/12/18 at 8:30 a.m., the APN stated that he had been called by the nurses because Resident #52 had cloudy and foul smelling urine. The APN stated that he ordered a urine c & S to rule out a UTI. He added that the resident's WBC were elevated. The APN stated that he ordered the urine c & s to be obtained by straight catheterization so he would have a good specimen with no contamination. The APN stated that the straight catheterization procedure involved two staff members, one to hold the resident's legs apart and one to insert the catheter. The APN also stated that the resident's communication was not always accurate and clear but admitted that if he had seen the resident and the directions were clear and simple, Resident #52 would be able to follow them in order to obtain a urine specimen through a less invasive procedure. The APN stated that he was not sure if he ordered the antibiotic for this resident or if it was the physician. In addition, the APN stated that he has not seen the resident since he last examined her in September. When asked, the APN stated that he was not familiar with the organism (Providencia Stuartii) identified in the urine c & s results. According to the progress note dated 10/09/18 at 15:20 (3:20 p.m.), Resident #52 completed the antibiotic therapy for the UTI. 2) When interviewed by the surveyor on 10/11/18 at 2:29 p.m., the Assistant Director of Nurses (ADON), in the presence of the DON stated that she was acting as the Infection Preventionist (IP). When asked about the facility's monthly Outcome Surveillance that was conducted for the residents with infections, the ADON presented the data, in the form of a line listing, but it did not include Resident #52 who had been identified as receiving an antibiotic to treat a UTI starting on 10/01/18. The ADON stated that she had missed this resident on the line listing. When interviewed, the ADON did not know the type of organism that prompted the antibiotic use for Resident #52. The ADON stated that residents should have signs and symptoms of a UTI that may include fever, delirium and a decrease in Activities of Daily Living (ADLs) before testing for a UTI is conducted. In addition, the ADON stated that the signs and symptoms of a UTI were not documented by the nurses or the APN prior to the invasive testing and the subsequent use of antibiotics for Resident #52. According to the facility's policy and procedure titled, Urinary Tract Infections/Bacteriuria-Clinical Protocol indicated the following: a) The nurses should observe, document and report signs and symptoms (for example, fever or hematuria) in detail and avoid premature diagnostic conclusions. b) urine odor, color and clarity are not adequate to indicate bacteriuria or a UTI. c) A positive urine culture .is not enough to diagnose a symptomatic UTI. d) Before diagnosing a UTI or urosepsis and ordering antibiotics, the physician should consider a resident's overall picture including specific evidence that helps confirm or refute the diagnosis of a UTI. e) Empirical treatment should be based on a documented description of an individual's symptoms and on consideration of relevant test results, co-existing illnesses and conditions and pertinent risk factors. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	f) Bacteriuria alone (an symptomatic UTI) should not be treated routinely, because treating it does not materially change outcomes, improve longevity or correct underlying problems. g) The physician should consider stopping antibiotics .in individuals with uncomplicated UTIs who have been afebrile and asymptomatic for at least 48 hours. NJAC-8:39-19.1(a), 19.4(d)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Implement a program that monitors antibiotic use. 10648 Based on interview and record review, it was determined that the facility failed to develop, promote and implement a facility wide system, with all the required components, to monitor the use of antibiotics. This deficient practice was evidenced by the following: 1) A review of the facility's Antibiotic Stewardship Policy and Procedure revealed that the policy and procedure did not include the assessment tool or management algorithm that would be used for infections, the mode and frequency of education to practioners and nursing staff and the physicians' and Advanced Practice Nurses' (APN) responsibilities to the use of antibiotic treatment. In addition, the facility did not implement the policy's guidance on the Infection Preventionist's responsibility to review all clinical infections that are being treated with an antibiotic and to audit providers' antibiotic prescribing practices. When interviewed by the surveyor on 10/12/18 at 8:31 a.m., the Corporate Administrator stated that she had provided the surveyor with the facility entire Antibiotic Stewardship policy and procedure. When interviewed on 10/12/18 at 8;30 a.m., the Advanced Practice Nurse (APN) who had ordered an invasive procedure to collect a urine sample on a resident stated that he had not received any training on the facility's Antibiotic Stewardship policy and procedure. (Refer to F880, example 1) NJAC 8:39-19.4(d)

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Keep all essential equipment working safely. 20349 Based on observations, documentation review, and interview on 10/9/18 in the presence of facility management, it was determined that the facility failed to maintain commercial clothes dryers in safe operating condition by failing to maintain the dryers free from lint accumulation. This deficient practice was evidenced by the following: At 12:15 p.m., the surveyor along with the facility's Director of Maintenance (DM) and Corporate Maintenance Manager (CMM) observed that 3 of the 4 commercial clothes dryers in the main laundry had a heavy accumulation of lint in the lower chamber. Lint had accumulated on the filter screen and fallen off from it weight, gathering along the floor of the chamber. In an interview, at the time, the facility's DM stated that the facility's policy was to clean the lint from the dryers every 2 hours. A sign on the wall confirmed this policy. A review of the facility's lint cleaning log revealed that the last cleaning was signed the night before (10/8/18) at 11:00 p.m There were no signed log entries for the 7:00 a.m., 9:00 a.m., and 11:00 a.m. scheduled cleanings. In an interview, at the time, the facility's Laundry Attendant (LA) stated that she cleaned the dryers that morning but did not sign the log. The LA also stated that she just dryed new towels which created all the lint. However, the surveyor observed towels in only 1 of the 4 dryers at the time. NJAC 8:39-31.2(e), 31.7(e)